Certification and Adoption Workgroup
Draft Transcript
March 12, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, and welcome, everybody, to the Certification and Adoption Workgroup call. This is a federal advisory committee, which means there will be opportunity for the public to make comment at the close of the call. Let me do a quick roll call. Larry Wolf from Kindred Healthcare?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'm on.

Judy Sparrow – Office of the National Coordinator – Executive Director
Adam Clark?

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman?

Paul Egerman – eScription – CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charles Kennedy? Marc Probst, I know, is joining late. Scott White?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Steve Downs?

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Micky Tripathi? Joe Heyman? Harry Tukeye? Carl Dvorak? George Hripcsak?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Joan Ash? Chris Brancato?

Chris Brancato – Deloitte – Manager, Health Information Technology
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anybody off? Okay. With that, I'll turn it over to Paul Egerman.

Paul Egerman – eScription – CEO
Good morning. Thank you for coming this morning to our call. Especially thank you on a Friday where I know there's some weather around the country, so I appreciate your participation. And I also want to take a minute and welcome, if there are any members of the public listening to our call. I appreciate your interest. I know some of the people who presented testimony a couple weeks ago said that they might be attending the calls, so I appreciate your continued interest. And I understand that Bakul Patel from the FDA is also listening, so I would like to thank you for your interest, and also thank the FDA for their help in providing us with information and answering questions when we ask them.

Before we get started, I wanted to very quickly sort of do a couple of administrative things, and talk a little bit about what we're trying to do in general and what the plan is. We actually have two issues sort of on our plate. One is the patient safety comments and recommendations. But also, the second one is the NPRM. An NPRM for certification was put in the federal register two or three days ago, and the NPRM is based on the recommendations that this group, this workgroup made back in August.

My own personal initial reaction to the NPRM is to say they did an excellent job. Since … recommendations, we really should be saying they did an excellent job. They did exactly what we were hoping they would do. But since that's also on our plate, I wanted to explain the schedule in terms of what we're planning to do. What we're hoping to do in today's call is to talk through this document called the working document and see how far we can get in it in terms of getting a sense of concensus about the direction that we're going to be heading on some of our recommendations.

Then what we're going to be doing is, based on information in this call, we're going to be revising that working document. We will be sending it to all of the individuals who presented testimony to us, and we will be asking them or soliciting their comments and feedback. We will also present it on March 17th, next week, to the entire policy committee. And so that will be a public presentation, and we will be asking for feedback from the policy committee on where we're reading. So we're sort of doing this like a work in progress and trying to get a lot of feedback along the way.

Then the following week, on March 25th, we scheduled another conference call. The purpose of that conference call will be two-fold. One will be to see what comments we might want to make on the NPRM because we have a short timeframe. We have to complete our comments by April 8th. And the second thing we're going to do on March 25th though will be to review whatever feedback we've gotten so far on our working documents and see how we want to start to adjust things.

Then we scheduled yet another call—I know it's a lot of calls—on March 29th, but the purpose of that is presumably that we have continued discussion on these issues, and hopefully try to finalize a series of recommendations that we would then present in April. I want to talk a little bit more about the agenda for today, but let me pause for a minute, having gone through that schedule, and ask the workgroup members if anything I said made any sense, if you have any comments or questions about what the process is that we're trying to do.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
This is Scott. No, that seems to be the process that we've explained for going on a week or so, so that seems to be consistent, Paul.

Paul Egerman – eScription – CEO
Great. Then what we want to do today is to go through this document called the working document. Now I think this was sent out to all the members of the workgroup. However, for members of the public, it was put on the HHS Web site. It was put on, I think, late yesterday, so you may or may not have it. If you don't have the working document, you're going to need it to go through the call with us. I will do my best to quickly describe how you can find it on the HHS Web site.

You first go to the portal page, which is healthit.hhs.gov. Then you go to, on the right, it says HIT Policy Committee. You click on that. Then you find where it says certification adoption workgroup, which is us. You click on that. Then you click on where it shows upcoming meetings. And then under upcoming meetings, you'll see our agenda, and you will see a place where you can download the working document. If you didn't understand all that, I'm sure you can e-mail Judy, and she'll do her best to help you.

What we're trying to do today then is to go through this working document. Now the working document came as a result of me first trying to summarize the meeting, and then we circulated this by e-mail to the members of the workgroup, and I did my best to include all of the comments that I got and tried to revise it. The first part of what is in the working document is a section called learnings and observations from hearing, and there are eight points on it.

And so, I circulated this, and then I kept circulating until I didn't get any more comments back from anybody. So I don't know if that meant that I buried everybody with e-mail, or if that meant that everybody was happy with what was written. So my first question is, is I want to first just focus on the first eight points where it says learnings and observations from the hearing. Are those – from the workgroup, is everybody happy with that? Does anybody have any questions, comments, or any issues there that you want to discuss?

Joan Ash – Oregon Health & Science University – Associate Professor
Are we looking, Paul, at what you sent Sunday?

Paul Egerman – eScription – CEO
Before I answer that question, the one thing I want to say is because we're on an open call with the public, when anybody speaks, please say your name first.

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan Ash, and I just asked that.

Paul Egerman – eScription – CEO
Great. The answer is yes. It's the same thing. What I sent out, the summary, I think I sent it out on Sunday in the e-mail. I took that, and I just made a PDF copy of that, and that's what's on the Web site. In other words, it should say on it learnings and observations from hearing. Do you see that on your document?

Joan Ash – Oregon Health & Science University – Associate Professor
Yes.

Paul Egerman – eScription – CEO
Then number one, overall patient safety is – is the way it starts, and so if that's what you've got, then you're looking at the right thing.

Joan Ash – Oregon Health & Science University – Associate Professor
Thank you.

Paul Egerman – eScription – CEO
As I say, the first part is I want to make sure that the learnings and observations, that that's the same; that we're all working from the same foundation because otherwise it would be very hard to discuss where we want to go next. Do we have any comments about these items? Are we comfortable with what's written here? Is there anything that's missing here?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Paul, it's Larry Wolf. In the … I lost the bullet number. Yes, in item number two, unfortunately, there's very little data about these hazards. I think, in a lot of ways, that's really a very powerful comment that we're making, that we're hearing anecdotal information, some of it with theoretical underpinning, some of it just incidents people have reported. And it's very hard, and I would suggest problematic for us to try to extrapolate the few data points that we have beyond the major point of, we don't have good data. So I know this is point number two. I'm thinking maybe in the wording. Unfortunately, there's very little data about these hazards. We need to do something….

Paul Egerman – eScription – CEO
You want to expand that in some way?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Either expand that or maybe just underline it because then you go into, then there appear to be … to address, and I don't want to lose the fact that while we all believe these large areas make sense, that we're really working in an area where we've historically collected very little information.

Paul Egerman – eScription – CEO
Yes. It's an interesting issue because, as I first wrote this, it was Joan, who is on the call, who brought forward the study that her group did that's actually probably one of the best studies. Tell me if I've got this right. You contacted every hospital in the country that used CPOE. Is that right?

Joan Ash – Oregon Health & Science University – Associate Professor
That's where we started. Some of them wouldn't talk to us, but everyone who would talk to us, we gathered data from.

Paul Egerman – eScription – CEO
Yes. But Larry's point, I think, is an excellent one. So you're saying, between these sentences, there needs to be something more said about the data and why – how we came to the conclusion that there were four areas of interest. Am I hearing that right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Maybe it's in recognition to the work of the people how came and presented. Maybe that would be a way to frame it or expand it a little bit of people have presented what was known, and there are acknowledged limits in the scope of what they could present because of a limited amount of research that's been done in this area. And so I guess I'm sort of putting this in here because we're later going to say we need to get better information.

Paul Egerman – eScription – CEO
Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
It seems to me that that was a really key message that we heard.

Paul Egerman – eScription – CEO
Do you want me to – okay. I think I understand. What I'll try to do, because I don't want to hold everybody up to try to draft this over the phone. I'll try to draft something and send it out, but the message I'm hearing is to elaborate on it that there hasn't been a lot of key studies. Perhaps to list the ones that we've got Joan's study. We've got data from the FDA, and that we're doing our best to extrapolate from it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Egerman – eScription – CEO
And to emphasize that there's a need for it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right, and maybe actually it is a learning observation. Maybe that is number two. It may be what you have as number two.

Paul Egerman – eScription – CEO
Yes. Well, the key there, I think you're saying, that's a good one is we're trying to say what we learned, and sometimes it's too much assumed. But one of the things we learned is we need data, and we don't really just straight out say it, so maybe what we should do is simply straight out say we need data, that that's one of the things to drive decisions. Very helpful, Larry. Other comments?

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan. Could I say something about number four?

Paul Egerman – eScription – CEO
Excellent. Yes. Number four was probably the most controversial issue. Yes, please go ahead.

Joan Ash – Oregon Health & Science University – Associate Professor
Because, again, there's a lack of data here about sharing among healthcare organizations, and if we could frame it that there was some testimony about that, but I'm not sure that usually not occurring, I mean, that sounds very strong, seeing that there isn't any data. Would it be possible to soften that and say, but is sometimes not occurring?

Paul Egerman – eScription – CEO
Actually, yes. You're looking at the one I did on Sunday. I heard that message from you, and the one that actually is put on the Web site said frequently not occurring.

Joan Ash – Oregon Health & Science University – Associate Professor
Okay.

Paul Egerman – eScription – CEO
So I changed it to usually to frequently because I thought frequently.

Joan Ash – Oregon Health & Science University – Associate Professor
It is true, I suppose.

Paul Egerman – eScription – CEO
If I change usually to frequently, which is actually what's on the Web site, does that respond to your concern?

Joan Ash – Oregon Health & Science University – Associate Professor
Thank you. Yes.

Paul Egerman – eScription – CEO
Frequently could be usually. It seems like we were debating how often it was occurring, and I'm not sure that that was necessarily the thing we needed to debate. It appears it's not always occurring.

Joan Ash – Oregon Health & Science University – Associate Professor
Yes.

Paul Egerman – eScription – CEO
And so perhaps that's a more accurate way of doing it. Now the other way that's interesting about number four, which is really responding to your comment, Larry, was we changed it. We didn't try to address some of these other things like nondisclosure agreements and hold harmless agreements because there was some controversy about how frequently those occurred, and we just focused on the end result that we really wanted to get, rather than trying to drive into some of those other issues. This is the thing that we really need that's not occurring.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Paul, this is Steve Downs. I'm wondering if there's just a little preamble at the start of this document that sort of makes the general point that we're reporting what we heard and, in many cases, what we heard isn't backed up by a lot of data that are available, but it's sort of the anecdotes and the impressions, and the experiences that the various sort of panelists offered and sort of puts it all in context in that way. I imagine we could go through a lot of these and have to make that caveat individually.

Paul Egerman – eScription – CEO
That's a great idea. That's a great idea. The other thing I was thinking about too is to try to put this in some perspective. I was just talking to a couple people from the FDA. I said, there's all this stuff in the press about this thing, people dying and everything. It looks like of grim. Are you trying to say that people shouldn't install these systems, that we should stop doing what we're doing? They said no. The FDA is not saying that at all.

They're just saying here's information that needs to be watched. No one is saying to not install these systems. No one is saying they're dangerous. They're just saying there are some issues that we've got to look at. I don't know if you think that there should be something like that written into the preamble or written at the end. Any comments on that?

I guess not, so … any other comments about the learnings and observations from the hearing? Okay. Are we then ready to go onto the section called possible recommendations and comments and start talking about that?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Sure.

Paul Egerman – eScription – CEO

Possible recommendations and comments, first we have the goal statement. Take a second to look at the goal statement because this is important. Are we all comfortable with this?

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
This is Steve Downs. Just a minor thing on the second sentence, under the goal, sort of a patient centered approach. Never mind. I'm misreading it. Skip it.

Jodi Daniel – ONC – Director Office of Policy & Research
It's Jodi Daniel. What do you mean by that? A patient centered approach to safety. What are you trying to … focus on the patient and less on accountability for an error? I'm not sure I'm quite understanding what you're saying here.

Paul Egerman – eScription – CEO
What was saying?

Jodi Daniel – ONC – Director Office of Policy & Research
Yes.

Paul Egerman – eScription – CEO
It's actually a good question because it's an interesting sentence. It actually came from – I forget. It was a physician at HHS who sent me an e-mail about it … actually fairly passionate. But basically, accountability for an error sort of suggests that what you're really looking for is the really egregious things that happened and who did what and why they did it. The patient safety centered approach really more focuses on making sure that we're creating safe conditions, that if there is a condition where there's potentially some confusion because of the way a screen appears or because of some process that's related to the computer system that could possibly cause a problem, that that is something that we want to be focused on. In other words, the entire focus is making sure that nothing harmful happens to the patient, and so focus on the patient.

Jodi Daniel – ONC – Director Office of Policy & Research
You're saying you're more focused on erring on the side of safety rather than liability for an error that occurs. Is that what you're trying to say?

Paul Egerman – eScription – CEO
That's correct. In other words, if you look down to a little bit about some of the testimony information about the concept of the PSO, you know, the idea being that there might be mechanisms for physicians to confidentially report the issues and possibly even capabilities for if you report something, your liability is somehow limited because you reported it. In other words, the focus really isn't on liability and errors. It's more of a focus on what do we need to do to make sure that this is safe for the patients.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Paul, it's Larry. I wonder if maybe the notion of proactive versus reactive might be appropriate here … explaining what you mean, because when you're talking about patient safety, and I really like the notion of creating safe conditions, is very much about, we want to put in place proactive things to maximize the safety of these systems. And, to me, accountability has too many other associations with it, and that maybe we should really focus on the second half of what you said about rather than just finding errors and dealing with the aftereffects of the errors.

Paul Egerman – eScription – CEO

Okay. I have that … do you want me just to remove that sentence that seems to be troubling? Patient centered approach focused more on the patient, less on accountability for an error. Maybe we should just take that out of the goal.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think what you said about creating safe conditions rather than trying to find and fix errors after the fact.

Jodi Daniel – ONC – Director Office of Policy & Research
Maybe you could just, in that sentence, say we want to prevent unsafe conditions that might lead to serious injuries or deaths, rather than focusing on errors after they occur, or something. Is that what you're trying to say?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yes.

Jodi Daniel – ONC – Director Office of Policy & Research
You might be able to just get both of those concepts in that last sentence.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yes.

Paul Egerman – eScription – CEO
I'll give that a shot, but as you can tell, doing the words isn't one of my strengths. I'm just like this MIT guy, so I'll do my best to send something out, but please feel free to fix it because I think whatever I'm do, I'm sure will be flawed, so I'd appreciate that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
…clarified the concept here, so thank you for that discussion.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Paul, this is Adam at Live Strong. One word that may be helpful here, at least, I mean, I truly appreciate the focus moving to the patient centric approach. But having some transparency as well so that patients, you know, and I think this is going to go into some of the work as far as achieving the goals, but patients aware of the information that's in their electronic medical record that's going to be important for them. So not only a patient centric approach, but a transparent approach where the patient is going to be able to access this information and relevant information pertaining to their treatment and care.

Paul Egerman – eScription – CEO
Okay. That's excellent. Other comments about the goal? I think the interesting part about the goal is also part of the last sentence. To achieve the goal of culture of improvement needs to be created. It's an interesting challenge to figure out how we help create a culture of improvement by each healthcare entity, but that's an interesting statement.

I assume then we're ready to go onto to the next series of recommendations. Now the way I tried to structure this, which may not be the most logical way of doing it. I thought I'd first put a patient engagement concept. Second, put a staff training or staff goal or training goal, and then third to talk about like the technology and the database. And that may not be the best way of doing this because it's sort of like the technology and the database is probably where somehow the headline is going to end up, but you never know.

Regardless of the format, what I wrote here for the patient engagement goal, based on some comments also that I got from you, Joan, that basically says it's picked up from Dave deBronkart's testimony. The patient can play a major role in identifying errors and preventing problems. And the interesting concepts here, what we're really saying is we're going to continue to encourage PHRs. We also say access by family members to inpatient medication lists should also be encouraged because that seems to be an area where there's some concern. We're really not saying very much more than just encouraging things, so let me pause a little bit and say, what are people's reactions to what's written here?

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Paul, this is Steve Downs. I know later in the discussion questions, you raise the point about should we be recommending sort of a path back for error correction. In other words, you're a patient. You look through your PHR at some of the data about you. You find some are wrong. Then the question is, what can you do about that? Ideally it should be fairly straightforward to be able to point out an error. I'd be in favor of actually including that in the recommendation.

Paul Egerman – eScription – CEO
Let me see. Let me just look at my list here. I think it's number four. It says that do we want to add a recommendation that says PHR certification data should be developed to make it easier for patients to report their clinician's questionable data. You're saying you would be in favor of adding that right here?

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
It's tricky for me because, honestly, I'm against certifying PHRs, but that's a longer discussion.

Paul Egerman – eScription – CEO
Well, there's two.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
I guess my thing is, I would actually say in terms of EHR certification, the ability for a patient to view and correct is something that we need to consider. But we need to consider that as part of sort of the broader certification content. Honestly, I lost a little bit of track of how far we've pushed in that direction. But certainly we can encourage that where there is patient access, that there be a path back to correction.

Paul Egerman – eScription – CEO
Actually, I really like your view of EHR instead of the PHR because the PHR puts certification in a whole new world because we've really not addressed that. But really, you're saying, make it part of the EHR certification that the patient access include a way to not necessarily correct, probably, but communicate.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Yes, exactly.

Paul Egerman – eScription – CEO
Corrections to their physician.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Right. From a sort of behavioral point of view, it has to be very simple to communicate back, you know, take action, essentially.

Jodi Daniel – ONC – Director Office of Policy & Research

But if it's for an EHR, doesn't that assume that you have a patient portal if you're talking about a patient being able to view the PHR to communicate back, which isn't necessarily, you're not necessarily going to have that in all.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
You're not, and I guess that was sort of the thing. I was a little hesitant to say that all EHRs should have patient portals, which I don't think we've sort of said is the certification criterion. I guess I was saying where that exists, that that be something that could be taken advantage of.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
This is Larry. I guess I've got two thoughts about bullet one that we seem to be talking around. One is, I think we are, in general, encouraged, wanting to encourage that the engagement with the patients includes a review of the information, as it is in the EHR, and that there is a method for acknowledging that data is incorrect. I'm trying to be really vague in general about that because I don't want to get into, the solution is the patient has the ability to correct it or enter correct things, or raise flags about this isn't me. You put information in here about another Larry Wolf, not this Larry Wolf.

I think it should be at the general level of – because it says here to encourage patients to be part of the entering, to be able to review the information with their providers, to be able to – that the systems support flagging of information that may be erroneous. And the second piece is, I would pull out from this the PHR piece other than the parts of meaningful use that already say that patients need to be supplied copies of their information.

Paul Egerman – eScription – CEO
I didn't quite understand what you were saying, Larry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I guess what I'm saying is, one of the safety issues that's been raised is information going into the wrong record.

Paul Egerman – eScription – CEO
Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
And the patient is the one, is one of the ones very able and likely to notice that.

Paul Egerman – eScription – CEO
Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
If they're ever given a chance to see it. And my expectation would be that if we're providing patients with summaries of their charts, or even a portal that we're not going to give them 100% access to everything. We're going to give them access to key things and summary things. And some of those may skip over, in fact, wrong information that needs to be corrected. I think the extent to which we involve the patients and review the information that come into their chart, that that helps strengthen the safety net here.

You give the example of an ambulatory setting, patients observe data as it's entered. That's certainly a place to catch an error. You know, picking the wrong patient, if they see that it's not their main one on the screen, that's a great safety net to go, that's not me you're writing about. Are you sure you have the right

chart? I think this notion of engagement is a key one. And I think it needs to be as much real time, and not – the PHR, my concern is that PHRs are going to be implemented very arm's length.

Paul Egerman – eScription – CEO
That's right, but the fundamental issue is, if I'm hearing these comments right, is the suggestion … I can't remember. It's either from Steve or Adam was that we tried to make it easier for patients to somehow point out and correct things.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Egerman – eScription – CEO
It actually came from a comment that Dave deBronkart made about the credit cards, the credit card industry. When consumers got access to their credit card bills and could easily click on a single line item and request confirmation, the industry cleaned up its act in terms of billing, and all of a sudden bills got to be really accurate. And so the idea, the initial thought was if there was a way for patients to do something similar, you could have a similar impact.

And so the issue that I'm hearing that we're wrestling with is if you put that on the PHR side of the world, I mean, I hear you say you'd like to do it real time. But the fact of the matter is, you can't always do things real time. And if you put it on the PHR side of the world, then you've got the certification group and everything. We've got to do an intellectual, logical jump to certifying PHRs, which we could do if we want, but that would be one way of doing it. If you put it on the EHR side of the world, which is just suggested, if I heard Jodi's comment, like, well, that sounds good, except that also implies that there's some sort of patient portal, which we could say that we could require, but that would be a logical extension. And so in terms of making it easy for patients to communicate directions, you know, and I suppose there's a third choice, which is, instead of having certification to provide guidance, which is weaker, but that would be a third choice.

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan. It seems like you've put it very well here, just saying that the PHR should continue to be encouraged. And maybe adding to the ability to review some of the data in the PHR, you could add and provide input … corrections.

Paul Egerman – eScription – CEO
Okay.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Paul, it's Scott. Just in terms, I mean, I know it's an example in the ambulatory setting issue. But it kind of leads us down the road of the patient observing the data, as it's entered. I mean, how realistic is it? I know it's just an example, but it doesn't seem to be possible in an ambulatory setting to have them sitting over the shoulder of the person entering the data. It's not generally done right at the moment, to be quite honest with you. And on an acute care setting, it most likely will never happen that way. Is the example opening up a broader spectrum in this area?

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan, and I'm the one who pushed for that because I really, truly believe that until the EHR is used, you know, they're using templates in the ambulatory setting in the exam rooms now, and I watched enough in those settings to see that this beautiful thing happens where the patient and the physician work together. It's not that they're observing the data as it's entered. It's just, they're having a conversation

about it. Often the patient will remind the physician to order such and such or a conversation develops. And I, frankly, don't think that ambulatory EHRs are going to have the impact they could have until they're used in the exam room where they're getting decision support through templates.

Paul Egerman – eScription – CEO
Thank you, Joan. This is also very generic statements, patients observe data as it's entered. I have to say, I have experience doing this with registration data. Patients can see the screen, as their registration data is reviewed and updated. My experience there is very positive. They find lots of little errors, and that may not seem like a patient care issue, but actually patient identification is a big patient care area. A lot of things go wrong right at the point where the patient is registered, and they accidentally create a duplicate because they get the data incorrect. I hear your concern, but I have to say, at least that's my observation.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Paul, I think there's a difference, though, between verifying information and being actual participant in the workflow of things. I think everybody would fully support, and that's kind of the context of this piece right here is patient involvement at some stage. It's just, when it's entered, I just don't think that that's functional, but that's my comment.

Paul Egerman – eScription – CEO
Would it help you, Scott, if we softened this? This says, for example, in ambulatory settings … in those ambulatory settings, when it is possible for patients to observe.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
That's a fair middle ground.

Paul Egerman – eScription – CEO
As I understand it, it's not always possible, but sometimes it is.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Absolutely. Where they have the ability to do so, I think that's the optimal point, but I just think that's more the exception than the rule.

Paul Egerman – eScription – CEO
Now I want to get back to this other issue that we're trying to discuss, which is facilitating the communications back. I mean, the reality is, you can't do everything real time, as you correctly pointed out, Scott. The reality is, with the interfaces and everything, there are errors in these records. The other reality is, patients could play a huge role in getting this thing fixed, and getting it right, and preventing errors.

The question is what. I get the sense that perhaps we would like to make it easier for patients to communicate problems back. In other words, if they see something now, what do they have to do? They've got to call the physician. They've got to send an e-mail … the screen. So the issue is what, if anything, should we be saying about facilitating a communication back about a correction from a patient to a provider.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Paul, this is Steve Downs. One of the thoughts I was thinking of is meaningful use, as it's currently proposed, does provide for a patient's ability to get at their data in some form.

Paul Egerman – eScription – CEO
Right.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
And I wonder if there is a way we could recommend extending that to say, you know, not only do they get access to their data, but that there is a simple method for them to alert the institution of any inaccuracies in the data.

Paul Egerman – eScription – CEO
Okay.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
And be fairly agnostic about how specifically that works.

Paul Egerman – eScription – CEO
That would be an approach where we would stop short of certifying, like a portal, but maybe perhaps a simple method because if you have a simple method, it probably means you actually have some portal or something where they can communicate. It's almost like we're encouraging a portal, but we're not requiring it.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
I guess that's where I'm going because I think there are probably a lot of permutations about how specifically to do this. You know, how to provide access to the data is going to take many forms. And then the return path could take many forms as well, and we should probably try to be fairly general about it while supporting the principle.

Paul Egerman – eScription – CEO
The suggestion is, in terms of facilitating the communication, Steve's suggestion is to encourage the use of a portal, but not require it as certification criteria. Do people have comments about that?

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
This is Adam. I would certainly agree with that. As I look at this, this is going to be a tiered approach anyway, but I do think, I know at least from Live Strong's end, we are engaging in the world of patient portals, and we do expect other patient advocacy groups to start working in this area as more as stewards of the information, as we try to be as close to the patient community as we can, hearing the information that they want, what information they're going to want from their electronic medical records. It's just not going to be ready for primetime clearly for years to come. But I think language encouraging the adoption so that different patient groups can really work on this with their constituents would be beneficial.

Paul Egerman – eScription – CEO
Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Paul, it's Larry. I actually really was impressed with your example of the credit card function where you can flag on a single item … an error. And so I have that model in my head, and I agree that I don't want us to be that prescriptive in how we should approach this. I'm thinking that what you said about wanting to be broadly covering of patient access by whatever method access is provided would actually be really good here. And if we wanted to name things, I think it's useful to name personal health records as one of the methods by which people get access.

But I don't want to push on that too hard because I think about your example and go, okay, so now I'm using some personal financial management tool that's downloaded my bank statements and my credit card statements, and using that tool, I notice that there's a charge that I didn't make coming from one of the credit cards. The comments about the PHR sounds like there's some way in that personal financial management software to say, you know, notify the credit card company that this isn't my charge, which is nice, but a long way from where we are today where we can actually go on the site.

Paul Egerman – eScription – CEO
True. You actually go to the item. To pick up on the comment about the credit card and the line item, part of the way I pictured this working, because a lot of this stuff has to do with medications, is the patient looks at their medication list, and in effect clicks on one medication. Sends a note to the physician that just says, I haven't taken this drug for two years, or clicks and says, I don't know what this is. I've never seen it before. By being able to click on it, that's a lot better than they have to – otherwise they've got to write it down or something, and call it in, and they may not pronounce the drug correctly. Just click on it, and you somehow write a little note that gets communicated. To me, that would be a powerful way to help clean up, especially the medication lists where there are issues about what's active and what's not, and what the patient is really taking.

Jodi Daniel – ONC – Director Office of Policy & Research
This is Jodi Daniel. At this point, is it possible to just, it sounds like people are all in agreement about the principle, just not necessarily the technology or the method for accomplishing it. Is it possible to capture the principle, give a couple of examples, but not necessarily lock it into a particular answer so that there may be different ways of reaching that goal of making it easy for a consumer to report an error or a perceived error in their records based on their access to the information and kind of not necessarily limit it to a PHR or a portal, but used as examples of ways that that could be achieved?

Paul Egerman – eScription – CEO
That's a good suggestion, Jodi, especially considering the process here where we're really creating a working document that's going to generate additional feedback. So let's capture the principle. Let's put it out there, and if people think we need to do something stronger, or the principle is good enough, we'll get the feedback on it. That's a great idea.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Paul, this is Adam. If I can just make one comment on that, and this would be brief, but in the example that's listed, it's talking about data that's entered. It does not talk about omission of data, so data that may not be entered, and just an example. One of our constituents was relaying a story that after she had a double mastectomy for breast cancer, her surgeon told her she was supposed to be on muscle relaxors. That order never got in to other doctor. She knew she was supposed to be on it though, but the other doctor had no record of it. So I think making sure that there's the ability to not only correct data that's entered, but having a conduit to say, I believe this data should be in there, but I see it nowhere.

Paul Egerman – eScription – CEO
Excellent comment. I appreciate that, Adam. I will include that.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Paul, just following up on Jodi's comment, it's Scott. When we talk about PHRs and such and patients going on the computer and clicking here, you know, that's under the assumption that the whole population is involved on the computer systems at the moment. And you know we have to be conscious of the fact that many of our disadvantaged populations don't have computers, so there's got to be almost another

mechanism for them to review their medical record. I suppose Jodi's point that maybe the how is not as important as the why.

Paul Egerman – eScription – CEO
Okay. Helpful comment.

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan because another example perhaps is a mechanism that wouldn't necessarily be through the PHR or a portal would be secure messaging, that capability, just as an example.

Paul Egerman – eScription – CEO
Okay. That's very helpful. I will write up a variation in this in which I try my best to capture all of these concepts, describe examples, and concepts as opposed to requiring certification of anything in particular. Are we ready to go on to the second recommendation, the staffing and training one?

Chris Brancato – Deloitte – Manager, Health Information Technology
Paul, before you move on, can I add something? This is Chris Brancato. The only thing that I think we have to be cognizant of is we're making an assumption that the physician is the source of the data. And the reality of it all is that the older data in the system, they may not have access to the source of the data to actually change it, for example, a laboratory of data.

Paul Egerman – eScription – CEO
That's true. Although, one of the ways we could respond to that, Chris, would be in the examples to say that where we initially want to establish this or where it's most important is in the medications list.

Chris Brancato – Deloitte – Manager, Health Information Technology
Yes. Understood.

Paul Egerman – eScription – CEO
You know what I mean. A very high percentage of the examples that we looked at in terms of the issues were with medications, and I think we know why that's the case, but that's where there's, if we at least start there, the hope I have, I don't know if it's right, but it gets back to the … improvement. You have the patient pointing things out, physicians and other people having to correct them. That helps lead to a situation where people say, well, let's try to fix this on the front end. We don't want to do this stuff all the time. You know, that's part of that cycle.

Chris Brancato – Deloitte – Manager, Health Information Technology
Yes. Actually, it's true. I'm living this with my own father, so I concur.

Paul Egerman – eScription – CEO
Hopefully we're ready to move on to the next recommendation, because I want to see how much of this we can get through today. The second recommendation relates to training processes and what was written here. I tried my best to reflect your comments, Scott. Do you want to make any comments about this?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Yes. Absolutely. Thank you, Paul. In many of the healthcare institutions, now part of their, what we call in service program, relates to many mandatory subjects, and it seemed to be an obvious end that patient safety and the training and the updating and a constant reminder would be hugely valuable, as all healthcare workers are probably the front line of patient safety, as it is. So it seemed that a

recommendation coming out of us to somehow incorporate that into the broader picture of the stuff would make a lot of sense. That's where my comments came from.

Paul Egerman – eScription – CEO
Is what's written here reflective of what you wanted to see? Did I get it right?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
You did well. Again, we're putting a lot of responsibility in the RECs, but that's where it's got to be, and they need to be a significant driver of this, and it's really got to change, come into the culture of these institutions. So it's where I'd spoken, and you captured it well.

Paul Egerman – eScription – CEO
Yes. The specific thing is, we're recommending that the RECs provide patient safety reporting information. In other words, they provide information to physicians and hospitals about how to report patient safety issues.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
It's Larry. Don't we want to be proactive in this recommendation in terms of making sure we have a safe – an implementation of a system that's less prone to error than more prone to error?

Paul Egerman – eScription – CEO
Who is speaking? Is that Joe?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'm sorry, Larry Wolf.

Paul Egerman – eScription – CEO
You're saying you want to be…?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
The RECs, what I'm suggesting is that we're actually asking the RECs to do more than just provide information on reporting. We're actually asking them to provide information on creating that culture of safety or that learning system with respect to safety. It's not just on the reporting side. It's also on the doing side.

Paul Egerman – eScription – CEO
That's a good observation, but before we go there, let's stay for a minute on this patient safety reporting side because that is something that I think is not perhaps – I don't know. Maybe it is, but I think we're introducing a new concept. Is everybody onboard with that? Do people think that that's a good thing to do, and it's a good recommendation that we ask the RECs to provide information about this? I assume silence is yes.

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan, and I'm just a little confused because the sentence about the RECs reporting, wouldn't that more logically go under number three, and then how would that fit in with the PSOs?

Paul Egerman – eScription – CEO
The picture I had about it is, the reason I put it under number two is patient safety reporting information could relate to the PSO, but it could relate to other things because there could be a requirement to do FDA reporting, for example. In other words, you could have a requirement to do both. And so the issue

is, however this thing turns out, that physicians should be trained as to what they're supposed to do, and have the information so that they know what they can do to report stuff.

Joan Ash – Oregon Health & Science University – Associate Professor
I see the training piece is clear that the RECs have a responsibility to train about patient safety and about how to report. But the sentence that says we recommend that the RECs directly do report.

Paul Egerman – eScription – CEO
No, it's not that they report. It's that they're providing information. Maybe I'd … information about how to report.

Joan Ash – Oregon Health & Science University – Associate Professor
Training, so could we change that information word to just training?

Paul Egerman – eScription – CEO
Yes. Yes.

Joan Ash – Oregon Health & Science University – Associate Professor
That solves the problem for me.

Paul Egerman – eScription – CEO
Yes. Sorry. That's again the MIT guy…. That's….

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
That's very good, Joan. That's perfect.

Paul Egerman – eScription – CEO
That's very good Joan. I knew what I was trying to say, but nobody else in the world did. That's a better explanation. With that clarification, I'm assuming that we all think this is a good idea, basically training on how to report patient safety issues so that people understand that. I want to then get back to what Larry said about you're trying to say that beyond this, we also want to have good implementation. Is that what you're saying?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'm going back to the very early discussion when we talked about creating safe conditions. The first sentence says, implementation and training processes has a significant impact on patient safety. Then we expand that as also should include reporting of safety, and then the recommendation is that the centers do the reporting piece. I think those recommendations should be that they also do the training on creating safe conditions and using the systems in a safe way. And whether that's verifying patient identity multiple times while … information in or when you see something – when you see an unusual lab result. The question, is it actually in the right patient's record? Those kinds of things that, of course … right record … but you need to teach people that it could be that someone screwed up when they stuck the label on the specimen.

Paul Egerman – eScription – CEO
Yes. Actually, I understand. I think it's an excellent comment. Especially when we're talking about this learning system and dissemination of information. RECs could play a very big role in all of that, so that makes sense. Excellent comments. Anything else on number two? It's all very exciting. We'll move on to the third issue, which is national database and reporting system.

Just a side comment, I understand that Sully, the U.S. air pilot, talked about this at HIMSS. Recommended it also, so we have somebody else recommending or at least agreeing with this recommendation, but here's where we talk about the PSO, the national HIT reporting system, and the specific recommendation that you see is that we recommend that stage two of meaningful use include a requirement that every hospital and eligible provider report potential hazards and incidents to the national PSO. Then we also incorporated George's comment that was, you need to keep in mind there's a lot more stuff beyond this, and this was not, by itself, a sufficient response. This is a good comment.

What comments do we have about this? This was also part of the guts of our recommendations. Silence means everybody loves it the way it is?

Jodi Daniel – ONC – Director Office of Policy & Research
This is Jodi Daniel. Just one question: This seems to assume that the PSO is the only approach for reporting that makes sense, and it might be the best one. I'm not sure. I'm just asking the question of whether or not the workgroup is endorsing PSOs over any other approach for reporting. I know that's what we heard at the hearing. I'm just wondering if there are other ways of doing this, other organizations, or if the PSOs really capture what you all think. You know, if they're set up in just the right way to capture all this information and handle it, that was my only question. I don't necessarily have an answer. I'm just posing a question to the group.

Paul Egerman – eScription – CEO
Yes. I guess it's a great question, Jodi. I guess the answer is, by making this recommendation, we're saying yes. There needs to be a single, national database of all of this, and the PSO, which is part of H.

Jodi Daniel – ONC – Director Office of Policy & Research
RQ.

Paul Egerman – eScription – CEO
RQ, if I'm saying it right, I don't know if government agency is a right word, but a government project. I think we are saying that's the national one we want. We're not necessarily saying it's the only one, but we're sort of choosing it by doing it this way. Although I suppose you could say, we could put PSO in small letters and let ONC decide if that's the right one. That would be another way we could do this. In other words, instead of saying the patient safety organization … we could say a patient safety organization, and let ONC choose whichever organization it wants to do. In other words, we don't necessarily have to choose one. We could make it more generic. There has to be a single database, and ONC go out and find one.

Jodi Daniel – ONC – Director Office of Policy & Research
I have no expertise on patient safety organizations. I don't know if others on the call know more than I do, but my understanding is there are multiple patient safety organizations nationwide, and I don't know that there is one single national PSO where there would be a national database and reporting system. I don't know if anybody knows the answer to that.

Joan Ash – Oregon Health & Science University – Associate Professor
If I could, this is Joan. AHRQ, the AHRQ, has a certain program called the patient safety organization program. And we heard testimony about it from AHRQ, and we chewed on this quite a bit, I think, and thought that that was a good option. Now maybe we'd want to say something like an organization such as AHRQ's patient safety organization, program, or something like that.

Jodi Daniel – ONC – Director Office of Policy & Research

I don't know that they have a national database. That's what my question is.

Paul Egerman – eScription – CEO
I thought they did.

Joan Ash – Oregon Health & Science University – Associate Professor
They do.

Jodi Daniel – ONC – Director Office of Policy & Research
Okay.

Joan Ash – Oregon Health & Science University – Associate Professor
At least they have the kernel of a national database.

Paul Egerman – eScription – CEO
Yes. It's my understanding. It's like a federal funded program. It has a national database. It has local databases. It has sort of like a hierarchy of all of that there. It had a common reporting format. We could certainly soften this a little bit to give ONC some flexibility to say, a national PSO, like Joan said, like the AHRQ.

Jodi Daniel – ONC – Director Office of Policy & Research
I mean, AHRQ is managing this program. I don't know enough about their program to know that there was, you know, you'd say to the PSO, and my understanding is that there are many patient safety organizations that are under the AHRQ program. That was why I was – I didn't know whether the national PSO is an accurate description of the AHRQ program. My understanding was there were multiple PSOs nationwide under AHRQ's program. That's just a factual question I don't know the answer to.

Paul Egerman – eScription – CEO
It's a good question. Actually, the way I understood what Bill Munier said was he did have a national one, but regardless of that, what sounds to me would give more flexibility would be to do, I think, what Joan said, which is simply change it from the PSO to a national PSO like the AHRQ program, and that gives us just the flexibility to see what else is out there and for ONC to do something a little bit different if they want. Is that responsive to your question, Jodi?

Jodi Daniel – ONC – Director Office of Policy & Research
Yes, and I could check with Bill Munier also about just to get more detail if that would at all be helpful.

Paul Egerman – eScription – CEO
That would be great, actually.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
It's Larry. Let me jump in. One of the things I think we heard was there needs to be consistency in the standards and what's reported. Maybe that should be a D bullet in here, somewhere on our list of things. We don't just want stuff reported. I guess if it's a national database, that implies that there's a single standard that's being used for what's reported, how it's coded.

Paul Egerman – eScription – CEO
Maybe the way we do that, Larry, is we're going to do directly to a national PSO organization with consistent reporting standards.

Joan Ash – Oregon Health & Science University – Associate Professor
Then you could say, such as the AHRQ, whatever the proper wording is.

Paul Egerman – eScription – CEO
Yes, that's exactly right – such as the AHRQ system. To pick up what you just said, because I think that was a big part of their claim to fame was they have this consistent format for reporting the data.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right, because I believe they actually were recognized in that there were local PSOs that were rolling up the data.

Paul Egerman – eScription – CEO
Okay. Excellent point, Jodi and everybody, so that's a helpful improvement. Excellent point. Other comments here? We're all set with number two?

M
Don't you mean number three?

Paul Egerman – eScription – CEO
Yes, I actually do mean number three. That's also an excellent comment. We'll go on then to number four. I think this was a suggestion from one of the presenters. I can't remember. Maybe it was Ross, or maybe George talked a little about this also. But it basically says establish certification criteria to make it easier for clinician users to immediately report any problems, concerns with information that appears on screens. This is the idea that there be some icon or something. If you click on the screen, it opens the dialog, and they can say this is totally completely confusing, and here's why. And it also would capture more information like the last two or three screens or something that the person has visited, so some IT person could figure out what's going on. Otherwise it's hard to communicate. Any comments about this issue? Are we okay with this one?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Paul, it's Scott. Did you get any feedback from some of the EHR companies about this proposal or that it's possible or it's a very problematic thing, just structural feedback on this? I mean, theoretically, I think it makes a lot of sense. Is it doable, and is it doable now kind of thing?

Paul Egerman – eScription – CEO
I did not get any negative feedback, and my understanding is that it is doable. I got the sense that it's being done to some extent already.

Joan Ash – Oregon Health & Science University – Associate Professor
Excuse me. We're talking about feedback buttons here?

Paul Egerman – eScription – CEO
Yes.

Joan Ash – Oregon Health & Science University – Associate Professor
Okay. It does seem like everyone has them. It's being able to capture the screens that might be a little less certain.

Paul Egerman – eScription – CEO

Yes, although that's not in the recommendations.

Joan Ash – Oregon Health & Science University – Associate Professor
Right.

Paul Egerman – eScription – CEO
In other words, the more you do, the better off you are. But this is more of a recommendation for, I like your terminology, feedback buttons.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Paul, it's Larry. Maybe I'm confusing things that no one else is confusing, so hopefully that's the case here. We've been talking a lot about wrong information in the chart, but this is really more focused on things that might be lab issues or screen navigation issues. And we talked about patients correcting things that appear to be wrong. Do we need something earlier that says it should be easy for a clinician user to indicate that they have a question about something in the chart, and then here in number four, we're talking more broadly about user interface issues or screen formatting? You know, odd screens that show up, really errors in the software.

Paul Egerman – eScription – CEO
Yes. In terms of clinicians, if there's some data wrong in the chart, I'd assume the clinician can correct it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
The clinicians can correct it if they have the information. They may not know what the correct information is. They may be saying I'm suspicious. This lab result looks like it's on a different patient. I don't know what the right lab result is, but I want to flag this. Are we presuming that that functionality is in the system, and my sense is, by and large, it is?

Paul Egerman – eScription – CEO
Yes. I'm listening to your example, but I'm confused. In theory, nothing gets into the record until a physician approves it. In practice, that's not the way it really works, but in theory that's the way it's supposed to work.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'm thinking about like lab results.

Paul Egerman – eScription – CEO
Yes, they're supposed to be signed off, but….

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
What's being signed off? It's being signed off that this is the right – this specimen ran through this machine. That's what the lab folks are signing off on, and it shows up in the record. And the doc may or may not comment on it in a progress note.

Paul Egerman – eScription – CEO
What you're really talking about is corrections process for clinician users who correct erroneous data in the record.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Egerman – eScription – CEO
I'll tell you what. If you don't mind….

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
…number one.

Paul Egerman – eScription – CEO
If you don't mind, I'm going to write that down, and let's come back to it in a minute, Larry, because I'd like to try to just make sure that we are in agreement with what number four has. The issue is, you look at number three where we talked about this national PSO. That's not just errors. That includes confusion screens, unsafe conditions, and three and four sort of go together in my mind because what we're really saying in four is we want to make it easy for providers to report unsafe conditions or problems.

Then number three, maybe we put this wrong too, but in number three, we're sort of saying they're making a recommendation about meaningful use. We're sort of saying we're going to give them an incentive to report. So we're giving them an incentive to report, and we're going to make it easier to report. We're sort of addressing this issue that we don't have a lot of data by doing this. We get a ton of data as a result of all of this stuff.

Number four is basically a recommendation for certification for what Joan called feedback buttons. The question I want to make sure, is this something that we're in favor of? Is there anybody who objects to it, and says we shouldn't do this? Okay. I'm assuming silence says that we are fine with that.

To return to your comment, Larry, you're really raising a different concept. You're saying the concepts that we were just talking about was reporting what appears to be unsafe conditions. You're saying, how easy is it for a physician to make a correction if somebody else's lab result is in the record. Is that correct? Is that what you're raising?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
That's correct, that we, in number one, emphasized that patients should do this, and I occurred to me, as we were looking at number four, that we'd actually have an assumption that it's easy for clinicians to do it, or clinician users to do it.

Paul Egerman – eScription – CEO
Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
…1B or something.

Paul Egerman – eScription – CEO
We have clinicians on the phone. George, do you have any comments about this? Are you there?

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan. Can I speak for the clinicians?

Paul Egerman – eScription – CEO
Absolutely.

Joan Ash – Oregon Health & Science University – Associate Professor

Usually that feedback button is a way to get to whoever supports your system, and some analyst will have the ability to correct. You know, often if you put something in the record, you're not allowed by law to correct it if you close the record. But the analysts have a way of making corrections legally.

Paul Egerman – eScription – CEO
Okay. So then the thing to do that you're suggesting would be to expand number four, so it's reporting what appears to be unsafe or unclear conditions, but it also might simply be an easy way to make a correction.

Joan Ash – Oregon Health & Science University – Associate Professor
Right.

Paul Egerman – eScription – CEO
Then that would respond to Larry's….

Joan Ash – Oregon Health & Science University – Associate Professor
I think so.

Paul Egerman – eScription – CEO
That's excellent. Are you okay with that, Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I am, as long as we keep it really general. My concern is … way oversimplify this. That we're going to create the equivalent of a comment box that's on the side of the wall that's meant for general feedback on, you know, the place is clean, and someone sticks a note in there saying my med list is wrong. It depends. It's all context sensitive. If someone is filtering, looking at those feedback things, looking for not just structural problems with the system, but real time problems that need to be addressed, I think that's great.

Paul Egerman – eScription – CEO
Okay.

Joan Ash – Oregon Health & Science University – Associate Professor
This is really important because maybe we could add something that there needs to be a response to that comment that comes in through the feedback button, a timely response or something.

Paul Egerman – eScription – CEO
That's true, although, again, in the first few sentences, the first few words, we recommend certification criteria. The certification criteria, really all it does is says the software has to have a certain capability. We can't, in certification criteria, say you've got to respond; you've got to have a timely response in 24 hours. We can recommend it, but it's just somehow that's not certification criteria.

Joan Ash – Oregon Health & Science University – Associate Professor
I see. It would be a mechanism for encouraging the two-way interchange, technically.

Paul Egerman – eScription – CEO
Right. Okay. Basically what I will do is I will expand number four to say it's for two purposes. One is to report the unsafe conditions, the confusing views, but also can be used to request corrections to data. Again, we're making it easier for physicians to request corrections to be made to data. Then I'll just add

some sentence that says because it's being used for these purposes, prompt, two-way communication is encouraged. Is that responsive to what everyone would like for number four?

Joan Ash – Oregon Health & Science University – Associate Professor
That's good.

Paul Egerman – eScription – CEO
Terrific. Now we're making terrific progress with all of these items. We're doing at least as well as I could imagine, so it's terrific. I want to start walking through some of these questions and topics for discussion. What I did with this is I just took everybody's e-mail and every suggestion or anything anybody said, I just wrote it down, so these are in no particular order.

The first one says, do we want to have a recommendation for a special HIT patient safety oversight function or an NPSB-like entity that investigates serious patient safety concerns? In other words, do want something more than just a PSO? Do we want some entity or organization that's like the NPSB that does something?

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Paul, this is Adam. I'm not going to say whether it needs to – I'd have to think about whether it should be a different entity than a PSO, but I do think that there needs to be an avenue for patients to report in on some of this that are serious concerns, and I don't know if anyone caught this in the news, but there were a few people over the past couple years that received incredibly high doses of radiation that were both computer and human error, apparently, that were never caught. And these things have an incredible knee-jerk reaction when patients start seeing this and then wondering, you know, really what are the safety measures when they go into hospitals using some of these systems. I do think that there needs to be a conduit for the patient community to either engage in discussions, report concerns, and try to get some feedback, outside of just clinicians reporting into this body.

Paul Egerman – eScription – CEO
Okay. I'll tell you what, Adam. If you don't mind, let me write that down as one of the topics that we want to discuss.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Great.

Paul Egerman – eScription – CEO
What I want to do is continue first on this topic of the patient HIT, patient safety oversight function, and get a couple of the items on the questions, and then I'll come back to that issue. The issue that's on the table is question number one. Do we think we need an oversight board, an NTSB-style board? You know, the NTSB plane crashes or something, and somehow a bunch of people show up, and they investigate it, and it has a lot of credibility. Do we need something like that, or is that too much too fast for us? Is the patient safety organization enough of a recommendation?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Paul, it's Scott. If we just leave it as patient safety oversight, have we not created a toothless tiger, if you will? And we've talked about a lot of blameless process here. But if there is an overt problem that has caused patient safety to be put at risk and people to be harmed, shouldn't there be some oversight, somebody looking over the shoulder to, A, investigate it, and not just have it reported. And, B, that leads us into a conversation of does that organization have some sort of ability to penalize. I mean, I throw it out there as a question, but I think, just going PSO alone is kind of weak.

Paul Egerman – eScription – CEO
You think we do need. You're answer to this question is yes.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Yes, I do think we need something there.

Paul Egerman – eScription – CEO
Okay. If your answer to your question is yes, what should we do? Should we just say there should be an oversight function? Should we say something more specific? When you say yes to this, what would you recommend?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
You know, it's a difficult balance here because you want to provide oversight, and you want to make sure that everybody is answering to somebody, if you will. But again, these things can be abused, and you can create such bureaucracy that it stymies a lot of stuff. So I don't know if I have an answer to the specific of who should it be or how should it look. But I do believe that it should have some sort of accountability other than just reporting it to a database.

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan. I'm wondering, because right now the joint commission looks at every single. They do route cause analysis on every single little issue already. Any organization that's already joint commission certified has to go through this. I mean, there is an oversight function now. And so what would this add to that?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Joan, it's Scott again. Is joint commission a voluntary that a process than an organization can submit themselves to, and you don't have to participate in joint commission?

Joan Ash – Oregon Health & Science University – Associate Professor
I think you have to if you want to be reimbursed by just about anybody.

Paul Egerman – eScription – CEO
Your answer to this question is no, you don't think we need this.

Joan Ash – Oregon Health & Science University – Associate Professor
I'm not sure. I don't know enough about it. It just seems that the joint commission is very watchful about this.

Chris Brancato – Deloitte – Manager, Health Information Technology
That's true for hospitals, but not physicians.

Joan Ash – Oregon Health & Science University – Associate Professor
Well, for ambulatory.

Chris Brancato – Deloitte – Manager, Health Information Technology
Right.

Jodi Daniel – ONC – Director Office of Policy & Research

This is Jodi Daniel. I'm wondering if this is something that you might want to take up at the full committee meeting as a discussion item and try to get some input from the broader policy committee since you will be going back and doing, you know, kind of chewing on these recommendations more. Just as a thought if there is sort of a … of if there's anything we, at ONC, could do to provide any input on existing practices that would be helpful.

Paul Egerman – eScription – CEO
That's a fair comment, Jodi, because when we report, to make sure everybody understands, part of reporting is we don't have to have a consensus on everything. If there's some issues that we don't have concensus, or we're undecided on, that's also something we can report on because that's valuable information. So it seems like we've got Scott saying that he thinks this is important. I've got Joan saying not so sure. And I just want to see if anybody else has any comments on this issue. What I'll do is then I'll just report the way you suggested, Jodi, is this is a topic that is being considered, but we don't have a strong concensus. In some sense, a lot of it does depend on AHRQ and how the PSO operates too in terms of the AHRQ, for example, does a fair amount of that function. So it's an interesting issue.

Unless there's objection, I'm going to go onto the next question. The next question is a totally different question, which is, do we want to add a recommendation that says – this has to do with certification. It's actually closer to the issues with communications and vendors that stage two certification process should cover vendor development and communication processes, which reflect some of the concepts of the FDA's QSR program, and certification should include requiring vendors to have a process that records patient safety problems and also communicates alerts to their customers.

This would be perhaps responsive to some of the feedback and concerns that were expressed during the testimony, but basically would say to be a certified EHR, among other things, you'd have to be able to have a mechanism for your customers to report patient safety problems, and you'd have to have a mechanism to provide that information back to your customers, as part of being certified, then also to look at some of these issues about quality manufacturing also as part of that process. This is a little bit of a leap for certification. What do we think of this?

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
This is Steve Downs. I think it's useful to put in here. Again, I think it's at a fairly high level, which basically says, you have a process for accepting concerns that users have, and you have an ability to notify people if there's anything they need to be careful about or any problems that have been discovered. In that way, I think it seems fairly commonsensical.

Paul Egerman – eScription – CEO
Any other comments? I'm going to interpret that … we'll add that to our list of recommendations. The next one on the list has to do with interoperability, and basically it suggested expanding the group of interfaces between applications. When I sent out the e-mail on this, I think I got a resounding no from Carl Dvorak. Unfortunately, Carl is not on the call, so I don't know if we want to discuss this. Does anybody else have an opinion on this issue? Do we want to defer this, so we could have a discussion with Carl on it? Do people have any comments about this issue? Let's defer it until Carl can participate because he was very adamant that that was not the right way to go.

Number four is the PHR certification criteria, which we already talked about, but in its place, why don't we raise the issue that Adam raised before, which was, the comment you made, Adam, was you said you wanted to make sure there was a way for patients to easily report information.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy

Yes. I mean, this, again, I think, is probably something to keep on a very high level and have discussions, but allowing for that line of communication from the patient and to a larger government entity or government supported entity because, as I look at a lot of what's going on now, it's either physicians to the entity or physicians to the vendors. And I think that there are going to be issues, probably unforeseen at this point, that patients will want to try to bring to the surface.

Paul Egerman – eScription – CEO
Are you proposing that patients should be able to, for example, report items to the PSO?

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
I'm leaning that way. I could, I'd like, again, to hear more. So maybe it's defining roles for patients in this. I mean, I'd have to give it some thought here.

Paul Egerman – eScription – CEO
Comments?

Joan Ash – Oregon Health & Science University – Associate Professor
Right now the organizations that I'm familiar with that have PHRs, the patient would access, would use the feedback button, just like a physician would, in order to get to an analyst would could then take care of any technical issues. That wouldn't be patient data as much as it would be, you know, if the patient had a comment to make about something wrong with the system. That might be a safety hazard.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
As I look at recommendation four, it looks good, from my end, at this point, particularly in light of those comments.

Paul Egerman – eScription – CEO
Yes, but you understand what we're saying about recommendation four was that I sort of crossed it off my list because we really accommodated this on a previous discussion about PHRs, so we're not really going to certify PHRs. The issue is, you're raising the question, Adam, of can patients communicate on safe conditions. And the comment I'm hearing back from Joan is, well, sure they can. But they can just use that feedback button, which means that really the communication is really back to the healthcare provider.

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
I guess I was thinking that maybe it's hard for us to envision it, but there could be circumstances where a patient notices that a healthcare organizations use of an EHR appeared unsafe to them, and it's less about their PHR or correcting data about themselves. They see something that they think is unsafe. And so, to have an ability to report that to a PSO, however lightly used that might actually be, I think, seems reasonable to add that in. In some ways, I think it would be harder to explain why the patient safety organization would not ever want to hear from a patient.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Yes. It's Scott. Along those lines, I mean, what's our downside to not allowing a patient to report to the PSO? I mean, other than they may get inundated with a lot of this, but I think it leads us open to why wouldn't you, and we're trying to engage the patients. That seems to be another opportunity to have them feel comfortable in reporting a problem where maybe the institution hasn't taken an action or something along those lines. There may be a disincentive for the institution to report themselves. I think we have to include it.

Paul Egerman – eScription – CEO

Any other comments on this? I think you ask a good question, Scott, that I was trying to think about. The only issue, it occurs to me, is maybe just the PSO isn't set up to deal with the public. Maybe they're accustomed to getting information from hospitals or physicians, and that getting it from the public is a slightly different thing.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
I'm thinking of it this way, Paul, that you, I, and everybody else loves to make a complaint that our records are just so poorly kept, and they're really inaccurate. Maybe coming back to the oversight group looking into it, maybe it's a poor model that they're using, or there's something that's really putting patient care at risk. The fact that one complaint doesn't maybe generate an investigation, but 50 would, 100 would. So the issue of setting it up to accept it, maybe we should recommend they're set up to receive them that way.

Paul Egerman – eScription – CEO
One of the questions I have, it's an interesting question, issue, that Scott and Adam are raising. We try to use the FAA as a model, and I wonder how the FAA handles this because I think passengers can do this, right? Passengers can file all kinds of complaints with the FFA if they want to. And so, as I think about it, I guess it makes a lot of sense. It sounds to me, if I'm hearing this right, we're going to have, to respond to your original issue, Adam, there are really two concepts. One is patients can use the feedback button, as Joan suggests, to provide feedback to their providers about things that they're concerned about, but that we're also going to try to provide a mechanism for them to report issues and concerns to the PSO.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Yes, I think those sound great. Again, I think it's worthwhile to investigate what some of this is, and listening to Scott's comments as well. Looking at FAA models, maybe an FDA model as well, you know, how do they capture concerns or adverse events, and what some of the advantages would be or limitations might be.

Paul Egerman – eScription – CEO
Yes. Perhaps some of our colleagues in the FDA during the public comment period can help us a little bit, but my impression is, which I might be wrong, is the way the FDA works on this is one mechanism is … manufacturer is required to report to comments, so I don't know whether or not the FDA gets comments directly from patients, but it'd be helpful to get that information. Excellent comment, Adam. Any other comments on this? Two patient feedback capabilities: one to the provider, and the other one is going to be directly to the PSO.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
And we may get three, Paul, when we get to number seven.

Paul Egerman – eScription – CEO
Okay. The next one on my list is a suggestion from, I think it was, George, who said that there should be – speaks a little bit to some of the comments also that we had on training and installation. But George said there should be a set of best safety practices for selecting, installing, using, and maintaining HIT, and disseminate those best practices to providers. Do we think we've already covered that, or do we think we need to say something separately on this topic?

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan. It does seem to be something that the regional extension centers could do, but they could not do. They could do the dissemination piece and the training piece, but this is something that hasn't

been done. There isn't a set of best practices yet that's clearly written, so I agree. I think this is something maybe we should very much encourage.

Paul Egerman – eScription – CEO
And why you say, I mean, I'm just looking at this list. Instead of best … practices or selecting, installing, using, and maintaining. Those are actually four different things. Are you saying, yes, we should do all four of those, Joan?

Joan Ash – Oregon Health & Science University – Associate Professor
Yes.

Paul Egerman – eScription – CEO
Okay. Who does it and how do we develop it? In other words, it's easy for us to say develop it, but is this something ONC does? How do these get created?

Joan Ash – Oregon Health & Science University – Associate Professor
I do know that it's something that AMIA has been thinking about.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Paul, this is George. I'm in an airport, so I can't go off mute normally, but I'm at a quiet point right now.

Paul Egerman – eScription – CEO
Terrific, and I think this was your comment, wasn't it?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. I didn't flush it out sufficiently. The choices are, one, I liked Joan's idea of AMIA. The other place is ONC kind of getting it from the RECs, the regional extension center. This is exactly what they're doing out in the field, and they have the most experience, will soon have the most experience in the world on what these practices are, so if we could collect that knowledge somehow from them and aggregate it at ONC, I think that would be the ideal way to do it.

Paul Egerman – eScription – CEO
It's sort of like ONC gets feedback from the RECs. ONC gets information from AMIA and other sources, and somehow facilitates the development of the…?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. I mean, it could be a small subcontract. I don't know what's legal or whatever, but a small subcontract to AMIA to gather the information from the regional extension centers and turning it into a document or a Web based … something reasonable. That would be like one idea.

Paul Egerman – eScription – CEO
Okay. That sounds positive to me. I don't hear anybody saying that we shouldn't do this, so I'm sort of interpreting these comments as, yes, we'll do this. And so I need to include this in our list of recommendations. The way I'm going to do it is, as I say, something like ONC should get feedback from the regional extension centers and from other sources, and facilitate the creation of a set of safety practices, so that we've opened the idea that they could do a contract, or they might just hold a conference or something to do that. Terrific.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I'm going back on mute into a noisy area, so I won't be able to go off again.

Paul Egerman – eScription – CEO
I appreciate your help. Thank you, George. Great comments. We're going to move on to the next issue, which is … do this one at a time or not, but I think everybody was really impressed with Jim Walker's like hazards evaluation tool—I don't know if I'm calling it by the right title—and Dave Classen's flight simulator. We were impressed with it, but the issue is, besides being impressed, should we be doing anything else? In other words, is there something else we should be saying or doing or making any recommendations concerning the expansion or utilization of those things because we like them a lot?

Joan Ash – Oregon Health & Science University – Associate Professor
I think we should. I think they're great models, and we should point to them as being great models.

Paul Egerman – eScription – CEO
Okay. But is there anything more beyond pointing to that? In other words, I'm sure they appreciate an accolade from us, but I'm not sure that that's necessarily….

Stephen Downs – Robert Wood Johnson Foundation – Assistant VP
Paul, this is Steve Downs. I guess one of the things I was wondering, if we're going to have a recommendation around developing best practices, maybe it's a way to say, to reemphasize, I think, something we put in the goal, which is around sort of not just reporting the really bad things that happen, but trying to focus much more on hazards and … sort of proactively prevent mistakes. And then use these as illustrative examples, and part of that, people should take a close look at these, which seem particularly promising.

Paul Egerman – eScription – CEO
So maybe….

M
Combine five and six?

Paul Egerman – eScription – CEO
Yes, combine it into five.

M
Yes.

Paul Egerman – eScription – CEO
And the first thing we should take a close look at that. Are we saying ONC should take a close look at it?

M
I was saying whoever is developing sort of the best practices.

Paul Egerman – eScription – CEO
Okay. That sounds good. Is there anything else we should be saying about these? I mean, I think … really excellent. Anything else we should be saying about these? We'll go with that. That sounds good.

The next topic on the list is number seven, the whistleblower issue, a couple of facets to this. The first question is, does whistleblower protection need to be expanded or changed as part of this process? The other interesting aspect is the community physician, one of which, incidentally, went to great efforts to call me and wanted to speak to me anonymously. I asked why. And he told me he's a solo practitioner in a

city where there was a single, dominant, integrated delivery network. And he was worried about being labeled a disruptive force. They made it difficult for him to speak out. I thought that was interesting information.

The question here is, this is a question that is also, I think, Scott, you had raised this issue. Is there anything we want to say about all of this area? Is this outside of our pay grade? Is this an area that we should be discussing?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
I think we should be discussing this. You know, it's really interesting that you got that call from the doctor. I hadn't gone to that level. I'm always thinking about it in terms of the workforce level. But we are a workforce committee, so it seems to be a logical area for us to make a recommendation, and full transparency is what we've been talking about since day one. That only happens when people don't feel retaliation or retribution, so it has to come with some protection for those who are raising an issue where the institution is not inclined to make a move on, so I fully support it. But then again, you would think I would.

Paul Egerman – eScription – CEO
What do you think we should do next?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Your phone cut out, Paul. I didn't hear the end of that.

Paul Egerman – eScription – CEO
I said, what should we do, in other words, about this topic? Should we hold a hearing? Do we have a discussion? Do we make a recommendation? I think it's an important issue, but I just don't know what we should be saying or doing about it.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
I mean, again, speaking from my constituency, that is a huge topic. For me, it's a very easy one, but I'd like to hear the other sides of why people would not want to have something along these lines. If the groups have thoughts on it, or we make a comment that we're discussing how to do this and, maybe in the future, have hearings on it. But I will tell you that you will get workforce to say, you know, we fully support this, but I need to know that I'm not going to be retaliated against. That's just an obvious one.

Joan Ash – Oregon Health & Science University – Associate Professor
This is Joan. I'm wondering if we need to mention the community physician. A, that's my first question because, in my experience, usually this is not something they would be terribly concerned about. But perhaps others in the workforce, you know, other healthcare professionals might be. And my other question is, does whistleblower protection not cover these employees right now? I'm thinking about maybe respiratory therapists who wants to report something having to do with the software in ventilators or whatever. Are they not covered now?

Paul Egerman – eScription – CEO
I guess my answer to that is, I'm not an expert at this by any means, but I think they're already covered. Plus, the way we're going to be handling the PSO is we want to give a mechanism for physicians, if they want to, or providers, if they want to include respiratory therapists, to report confidentially, so that although the best practice would be to identify yourself and, actually, also notify the vendor, but also to give them a vehicle to report confidentially so that that should handle it. I suspect, and I don't know for

sure, that the whistleblower protection doesn't help the community physician because he's not an employee. He's sort of like a different person, but I don't know how that works.

Joan Ash – Oregon Health & Science University – Associate Professor
Then I question somewhat whether this is really an issue. I'm sitting in a community hospital right now, and they can be a disruptive force, but they're so cherished.

Paul Egerman – eScription – CEO
Right. The comment I'd give you there, Joan, is that's correct. They are cherished when it's a community hospital, but it's a different environment when there's a single, dominant, integrated delivery network. In a community hospital, the reason why the physicians are cherished is physicians can sort of vote with their feet. Usually, if they don't like what's going on, they could go someplace else, and so there's a nice mechanism to make sure that they're cherished. It's not necessarily the same in every location.

Joan Ash – Oregon Health & Science University – Associate Professor
Maybe this is a bad – maybe we would want to use a different example then.

Paul Egerman – eScription – CEO
That's true.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Or we can just do generic, you know, recommendation that anybody who raises an issue should be protected or not retaliated or no adverse reaction come to them because of them reporting a patient safety issue. And eliminate the example of the physician in this, in that, but evidently, Joan, to your question is, you don't think it happens, but somebody had the wherewithal to call Paul today it does happen.

Joan Ash – Oregon Health & Science University – Associate Professor
I understand. But again, we have so little data.

Paul Egerman – eScription – CEO
Here's what I'm going to do because I'm also looking at the clock, and we want to give time for public comment. What I'm going to do is, in our notes, is to say we did not finish the discussion of this topic. Certainly nobody would object to what you said, Scott, that there would be no retaliation. But let's sort of pause the discussion and see if we can get some more information. And we also didn't finish the list, although we got a lot further on the list than I thought we would in this call.

Let me just explain what we're going to do next. What's going to happen next is that I'm going to do my best to write this all up, and I will send out a revision of the working document to everybody, and I'll try to do that sometime over the weekend. What I want to invite you, encourage you to do is after you get it, to fix it, because I'm sure I won't quite get it the way it should be, but feel comfortable to make the edits and try to fix it, so that it does correspond correctly with what was said in today's call. Then after we get that done, I'm going to send it to the people who presented and invite them to give us their suggestions, and then we'll present it, as I said, on the 17th, getting more feedback, and then we'll continue our discussions on the 25th.

Having said that, let me ask, does anybody have any more comments before we open ourselves for public comment? Is everybody comfortable? Does anybody have anything else they want to say about any of these issues? Terrific.

Now we will start the public comment phase. For the people who may be on the phone, we never know if there's nobody who wants to make a comment or a lot of people who want to make a comment, but if people want to make a comment, I will stay to listen to all the comments. And to make sure people understand, I know there's at least possibly at least one journalist in the public, but the way the public comment works is people make comments to us. We do not actually answer questions. We simply listen to feedback that people want to give to us. Judy, could you see if we have any public comments?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. Operator, could you alert the people on the line how to dial in or tap into it?

Operator
(Directions given.) We have one on the line.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Would that person please introduce themselves and their organization?

Operator
Our comment comes from Shelley Looby.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Shelley Looby – Cerner – Director of Regulatory Affairs Quality Assurance
Shelley Looby, Cerner Corporation, Kansas City, Missouri. You were asking earlier, Paul, about whether the public could report issues to FDA. There are consumer complaint coordinators that FDA has set up, and there is a toll free number for every state in the union for the public to call complaints into the FDA with regards to regulated products or health related products.

Paul Egerman – eScription – CEO
That's very helpful, Shelley, and you were one of our presenters.

Shelley Looby – Cerner – Director of Regulatory Affairs Quality Assurance
That's correct.

Paul Egerman – eScription – CEO
I very much appreciate that information. Did you have other comments about what we talked about today?

Shelley Looby – Cerner – Director of Regulatory Affairs Quality Assurance
No. No, just wanted to make sure that they had that information out there that there is a way for the public to report to FDA.

Paul Egerman – eScription – CEO
Terrific. That's very helpful.

Judy Sparrow – Office of the National Coordinator – Executive Director
Any other public comments? Okay. Thank you.

Paul Egerman – eScription – CEO

Thank you, and I'd like to once again thank all the members of the workgroup for your excellent participation. This has been an extremely exciting topic, a very interesting topic, and these are very thoughtful comments. Thank you very much, and we'll be sending out an e-mail very soon. Thank you very much to Judy Sparrow, Jodi Daniel, and to the HHS team.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

M
Thank you, Paul.

Paul Egerman – eScription – CEO
Take care. Bye.

M
Thank you, everybody.